



SEIUHealthcare®

United for Quality Care

Keith Kelleher
President

April Verrett
Executive Vice-President

Myra Glassman
Secretary-Treasurer

Vice Presidents:

Jaquie Algee
Erica Bland

Felecia Bryant
Anthony Guest

Alex Han
Terri Harkin

Greg Kelley
Maggie Laslo

Paula Richard
Brynn Seibert

Board Chair:
Flora Johnson

Vice-Chairs:
Faith Arnold
Bernita Drayton
Francine Rico
Alberta Walker

Illinois

2229 S. Halsted St.
Chicago, IL 60608
Phone: 312.980.9000
Fax: 312.939.8256

Indiana

1800 N. Meridian Street
Indianapolis, IN 46202
Phone: 317.927.9691

www.seiuhealthcareil.in.org

January 22, 2014

On behalf of the 91,000 members of Service Employees International Union Healthcare Illinois-Indiana, we appreciate the opportunity to comment on Illinois draft 1115 waiver application. As the largest union of direct care workers in the state, we believe we contribute a unique voice to the continuing discussion of system transformation. Our comments here follow on and amplify points made in our comments on the 1115 concept paper and our input in the Alliance for Health steering committee, and anticipate continued engagement in the 1115 waiver stakeholder process.

At the outset of these comments we should say we are concerned about a lack of detail in the application draft, especially regarding many proposed major transformations. This makes it difficult for us to assemble our comments. While we understand some of the details will be in an implementation plan, there are many sections of the application marked that detail will be filled in later, and places where dollar amounts are left blank so we cannot know if the proposed initiative is large or small.

Though all this may make it difficult for us to be effective as stakeholder-partners, SEIU HCII continues to support the vision of an integrated, efficient, and rebalanced Medicaid system that is behind the application draft. Our comments below are grouped in three broad areas of focus, changes to home and community based services; health care delivery system transformations; and workforce issues. Many of our comments on workforce issues overlap with the other two areas since it is nearly impossible to discuss proposed changes without discussing workforce supports necessary.

Home and Community Based Services

Proposed HCBS changes in the waiver application are immense in scope. 1915(c) waiver consolidation will be a quite complex process. Of all the changes, we have the most questions/concerns about standardization of service array and of rates. While SEIU HCII supports the basic principle of allowing consumers to choose services across the population categories that exist in 1915(c) waivers today, standardization could have negative effects depending on how it is done. The standardization process must not result in cuts to services to any populations. We have similar concerns with the rate standardization called for in the application. These must not be done in a way that decreases access for anyone.

The application also calls for “outcomes-based” reimbursements for HCBS. We are aware of few if any currently operating outcomes-based reimbursement systems in Medicaid or state-funded HCBS; at minimum we do not know of one that has been running long enough that it has established a track record and lessons learned for how best to design such a system. Even with the listed proposed measures for services for individuals with developmental disabilities, it remains difficult to imagine how analogous measures would appropriately be developed and applied to other HCBS. We believe stakeholder engagement in how these evolve should be a particular priority because the impacts of outcome measure design on HCBS programs could be substantial.

We support the principle that provider assessments should be available as an important tool to strengthen funding of HCBS. There is no reason this tool should be available only for institutional services. Given the state’s admirable commitment to strengthening HCBS, securing a provider assessment should be a priority. The state’s other HCBS initiatives will be difficult to realize without more funding in the system. We want to work with the Governor’s Office, state agencies, and federal CMS on changes at the federal level to make a provider assessment possible. We also believe the state should explore other avenues for bringing more funding into the HCBS system as well.

We urge that the definition of personal assistant in the waiver must be fixed. At present it is inadequate because it is rigid, not flexible enough to describe the scope of what personal assistants really do. At present the definition only covers services at the consumer’s home and work (if applicable), not any sort of services that might be provided out in the community. Also the definition at present states that the personal assistant is employed by the consumer. This needs to be clarified to reflect that the consumer is in fact the employer for certain functions but the state is the employer for other functions.

Lastly and perhaps most importantly, SEIU HCII firmly believes none of the proposed initiatives in HCBS will truly work without major workforce investment. This rapidly-growing field has been set up largely consisting of low-wage work with few training resources and not enough thought given to workforce development. This must change for integrated delivery systems that include LTSS to work. We urge that the state should commit to development of training resources such as a standardized and enhanced curriculum for homecare workers and other direct providers of LTSS. The training standards should reflect the new needs of integrated delivery systems. We also specifically recommend inclusion of the enhanced home care program that appeared in the full State Health Care Innovation Plan in the 1115 waiver. Also, simultaneous with training, investment in workforce should mean raising wage and benefit standards to stabilize the workforce and lift those who do this vital work from poverty.

Health Care Delivery System

The application’s section titled “Pathway 1: Transform the Health Care Delivery System” begins by describing startup investment in new integrated service delivery models, through the state’s new Innovation and Transformation Resource Center and otherwise. SEIU HCII urges that these resources should be available to actors such as safety net hospitals or HCBS providers, and designed with their

needs and challenges in mind. For example, technology assistance should prioritize safety net providers endeavoring to participate in integrated delivery models and facing challenges. Delivery system transformation goals are less likely to be met if such resources all go to providers that are basically ready to participate in new delivery systems already or are well-positioned to do so without state resources.

We also believe success of proposed delivery system transformations will depend on the extent to which emerging workforces on which the envisioned new delivery system depends are supported and included. We support creation of a training curriculum for Community Health Workers, in addition to training resources for direct service workers in HCBS described in our comments above. We believe delivery system transformation also means ensuring inclusion of these workforces in robust ways in integrated delivery systems. For example, changes such as including homecare workers in multi-disciplinary teams for coordinated LTSS should be a major focus of new thinking on team-based care to which the state is committing. Another example would be incumbent worker training within health systems so experienced workers can take on new roles in care coordination models.

We agree when the state identifies specific health system transformations as a major focus of healthcare reform in the current moment, and have several comments on tools proposed to help achieve these transformations. In the Health System Integration and Transformation Performance Program, some part of payments should be based on how much providers improve during a time period, rather than on an absolute score, to ensure all hospitals will engage in the transformation work the state seeks to encourage. The measures selected should include one “process” measure as well, staffing level, because it is so compellingly linked to so many quality outcomes. The advisory committee that will select measures should include representatives from the “distressed hospital” group and the hospital workforce. In the Hospital Access Assurance Program, the state may wish to consider definitions of “safety net” or a hospital’s role in assuring access beyond the mechanism of converting losses in historical Medicaid UPL.

Lastly, in seeking to “right-size” nursing home capacity through the proposed Nursing Facility Closure and Conversion Fund, there should be plans in place to re-train workers. This should be part of the fund mechanism itself, which as proposed at present treats financing needs of facility ownership as more or less the only need for which money would be allocated specifically. Consideration of economic impact on the surrounding community certainly should consider these workers; ideally with re-training they may be a resource for the many workforce needs for the new delivery system as well.

Workforce

As stated previously, many of our comments on workforce strategies and supports are set forth above because they overlap so much with the delivery system transformation and HCBS areas. Specifically we support: development of training resources for homecare workers and other HCBS workers; enhanced training standards for HCBS workers reflecting new IDS needs; inclusion of an enhanced home care program in the waiver application; creation of a training curriculum for Community Health Workers;

inclusion of front-line workforces in IDS models in robust ways, such as through inclusion of homecare workers in multi-disciplinary teams when appropriate.

In particular we are encouraged that ensuring all health care workers are paid a living wage is a primary goal of the workforce development strategy described in the waiver application. We believe the health care system should be built on living wages. We know well, though, that this will be difficult to achieve. In our comments on the concept paper we suggested the state should ensure wage increases were built into the cost curve to demonstrate budget neutrality. In the draft application, the state does not say how living wages for health care workers will come about.

In Conclusion

SEIU Healthcare Illinois-Indiana believes the system changes proposed in Illinois' 1115 waiver application draft are worthy of the extensive continued effort it will take to secure approvals and make them a reality. We are encouraged by attention that has been paid so far in the Alliance for Health and 1115 waiver to workforce investment, population health, and the role of fighting poverty in a struggle to achieve better health outcomes, though we have some concern over absence of some details from the application draft. We eagerly look forward to being informed as those details are filled out in the near future. We believe assurance of a continued transparent stakeholder process should be considered an important part of the transformation the state is hoping to effect. So we look forward as well to continued engagement in transparent stakeholder discussions to help shape an implementation plan.

A handwritten signature in black ink, appearing to read "Keith Kelleher".

Keith Kelleher, President, SEIU-HCII